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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: EILEEN DIANE NELSON P.O. Box 133 Cherry Tree, PA 15724 Registered Nurse License No. 649252 Respondent.	Case No. 2009-304 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about December 7, 2004, the Board issued Registered Nurse License Number 649252 to Eileen Diane Nelson ("Respondent"). Respondent's registered nurse license expired on November 30, 2008.

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STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct . . .

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
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> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> . . . .
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

7. Code section 4060 states, in pertinent part:

> No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052. This section shall not apply to the possession of any controlled substance by a

manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, when in stock in containers correctly labeled with the name and address of the supplier or producer . . .

8. Health and Safety Code section 11173 states, in pertinent part:

(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge . . .

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES AT ISSUE

10. "Demerol", a brand of meperidine hydrochloride, a derivative of pethidine, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(17).

11. "Morphine/morphine sulfate" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

12. "Dilaudid", a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K).

13. "Lortab", a combination drug containing hydrocodone bitartrate and acetaminophen, is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4).

14. "Ambien", a brand of zolpidem tartrate, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(32).

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FIRST CAUSE FOR DISCIPLINE

(Diversion and Possession of Controlled Substances)

15. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (a), in that on and between January 27, 2006, and February 5, 2006, while on duty as a registered nurse in the surgical unit at Memorial Medical Center, Modesto, California, Respondent did the following:

Diversion of Controlled Substances:

a. Respondent obtained the controlled substances Demerol, morphine, Dilaudid, Lortab, and Ambien by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows: During the time period indicated above, Respondent removed various quantities of Demerol, morphine, Dilaudid, Lortab, and Ambien from the Pyxis under the names of Patients A through E, but did not chart the administration or wastage of the medications in the hospital/patients' records and otherwise account for the disposition of the controlled substances, as set forth in paragraph 16 below. Further, Respondent removed Demerol for Patients A and B and Dilaudid for Patient C in doses that were in excess of the quantities ordered by the patients' physicians.

Possession of Controlled Substances:

b. During the time period indicated above, Respondent possessed unknown quantities of the controlled substances Demerol, morphine, Dilaudid, Lortab, and Ambien without valid prescriptions from a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor, in violation of Code section 4060.

SECOND CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

16. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that while on duty as a registered nurse in the surgical unit at Memorial Medical Center, Modesto, California, Respondent falsified or made grossly incorrect, grossly

inconsistent, or unintelligible entries in the hospital/patient records pertaining to the controlled substances Demerol, morphine, Dilaudid, Lortab, and Ambien, as follows:

Patient A:

a. On January 27, 2006, at 0456 hours, Respondent removed Demerol 50 mg from the Pyxis under Patient A's name, when, in fact, the physician's order called for the administration of only 25 mg Demerol for the patient. Further, Respondent failed to: chart the administration of the Demerol in the patient's medication administration record ("MAR"), document the wastage of the Demerol in the Pyxis, and otherwise account for the disposition of the Demerol 50 mg.

b. On January 27, 2006, at 0544 hours, Respondent removed Demerol 50 mg from the Pyxis under Patient A's name, when, in fact, the physician's order called for the administration of only 25 mg Demerol for the patient. Further, Respondent failed to: chart the administration of the Demerol in the patient's MAR, document the wastage of the Demerol in the Pyxis, and otherwise account for the disposition of the Demerol 50 mg.

Patient B:

c. Between February 4, 2006, at 1918 hours, and February 5, 2006, at 547 hours, Respondent removed a total of 950 mg of Demerol from the Pyxis under Patient B's name when, in fact, the physician's order called for the administration of Demerol 50 mg every 3 to 4 hours as needed for the patient. Further, Respondent failed to: chart the administration of the Demerol in the patient's MAR, document the wastage of the Demerol in the Pyxis, and otherwise account for the disposition of the Demerol 950 mg.

Patient C:

d. On February 4, 2006, at 2050 hours, Respondent removed Demerol 100 mg from the Pyxis under Patient C's name, documented in the Pyxis that she administered 50 mg of Demerol to the patient and wasted the remaining 50 mg, as witnessed by another nurse ("Rose L."), but failed to chart the administration of the Demerol in the patient's MAR or otherwise account for the disposition of the Demerol 50 mg.

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e. On February 4, 2006, at 2114 hours, Respondent removed Demerol 100 mg from the Pyxis under Patient C's name, documented in the Pyxis that she administered 50 mg of Demerol to the patient and wasted the remaining 50 mg, as witnessed by another nurse ("Christine"), but failed to chart the administration of the Demerol in the patient's MAR or otherwise account for the disposition of the Demerol 50 mg.

f. On February 4, 2006, at 2205 hours, Respondent removed Demerol 100 mg from the Pyxis under Patient C's name, documented in the Pyxis that she administered 50 mg of Demerol to the patient and wasted the remaining 50 mg, as witnessed by another nurse ("Aundrea"), but failed to chart the administration of the Demerol in the patient's MAR or otherwise account for the disposition of the Demerol 50 mg.

g. On February 4, 2006, at 2207 hours, Respondent removed morphine 4 mg from the Pyxis under Patient C's name, but failed to: chart the administration of the morphine in the patient's MAR, document the wastage of the morphine in the Pyxis, and otherwise account for the disposition of the morphine 4 mg.

h. On February 4, 2006, at 2242 hours, Respondent removed Demerol 100 mg from the Pyxis under Patient C's name, documented in the Pyxis that she administered 50 mg of Demerol to the patient and wasted the remaining 50 mg, as witnessed by another nurse ("Jennifer L."), but failed to chart the administration of the Demerol in the patient's MAR or otherwise account for the disposition of the Demerol 50 mg.

i. On February 4, 2006, at 2330 hours, Respondent removed morphine 4 mg from the Pyxis under Patient C's name, but failed to: chart the administration of the morphine in the patient's MAR, document the wastage of the morphine in the Pyxis, and otherwise account for the disposition of the morphine 4 mg.

j. On February 5, 2006, at 0120 hours, Respondent removed 1 morphine PCA/drip (150 mg/150 ml bag) from the Pyxis under Patient C's name, charted on the PCA flow sheet that she administered the morphine to the patient at 0130 hours, but failed to chart the administration of the morphine in the patient's MAR or otherwise account for the disposition of the 1 morphine PCA/drip.

k. On February 5, 2006, between 0113 and 0349 hours, Respondent removed a total of 12 mg of Dilaudid from the Pyxis under Patient C's name when, in fact, the physician's order called for the administration of Dilaudid 4 mg every 3 hours as needed for the patient. Further, Respondent failed to: chart the administration of the Dilaudid in the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 12 mg.

l. On February 5, 2006, at 0457 hours, Respondent removed a total of 4 mg Dilaudid from the Pyxis under Patient C's name, but failed to: chart the administration of the Dilaudid in the patient's MAR, document the wastage of the Dilaudid in the Pyxis, and otherwise account for the disposition of the Dilaudid 4 mg.

Patient D:

m. On February 4, 2006, at 2157 hours, Respondent removed morphine 8 mg from the Pyxis under Patient D's name, but failed to: chart the administration of the morphine in the patient's MAR, document the wastage of the morphine in the Pyxis, and otherwise account for the disposition of the morphine 8 mg.

n. On February 4, 2006, at 2240 hours, Respondent removed 1 tablet of Lortab 7.5 mg from the Pyxis under Patient D's name, but failed to: chart the administration of the Lortab in the patient's MAR, document the wastage of the Lortab in the Pyxis, and otherwise account for the disposition of the 1 tablet of Lortab 7.5 mg.

o. On February 4, 2006, at 2340 hours, Respondent removed morphine 8 mg from the Pyxis under Patient D's name, but failed to: chart the administration of the morphine in the patient's MAR, document the wastage of the morphine in the Pyxis, and otherwise account for the disposition of the morphine 8 mg.

p. On February 5, 2006, at 0431 hours, Respondent removed 1 tablet of Lortab 7.5 mg from the Pyxis under Patient D's name, but failed to: chart the administration of the Lortab in the patient's MAR, document the wastage of the Lortab in the Pyxis, and otherwise account for the disposition of the 1 tablet of Lortab 7.5 mg.

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Patient E:

q. On February 4, 2006, at 2239 hours, Respondent removed 1 tablet of Ambien 5 mg from the Pyxis under Patient E's name. Respondent charted in the patient's MAR that she administered the Ambien to the patient at 2240 hours, but placed her entry in the wrong area of the MAR (under the medication Xanax).

r. On February 4, 2006, at 2240 hours, Respondent removed 1 tablet of Lortab 5 mg from the Pyxis under Patient E's name, but failed to chart the administration of the Lortab in the patient's MAR, document the wastage of the Lortab in the Pyxis, and otherwise account for the disposition of the 1 tablet of Lortab 5 mg.

s. On February 4, 2006, at 2303 hours, Respondent removed 1 tablet of Ambien 5 mg from the Pyxis under Patient E's name, but failed to chart the administration of the Ambien in the patient's MAR, document the wastage of the Ambien in the Pyxis, and otherwise account for the disposition of the 1 tablet of Ambien 5 mg.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 649252, issued to Eileen Diane Nelson;

2. Ordering Eileen Diane Nelson to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: 5/28/09

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant

03579-110-SA2008305660